JOHNSON HEALTH & WELLNESS CENTER

Dr. Karl R.O.S. Johnson, DC, DNMSc, BCIM

Author of: *"Reclaim Your Life: Your Guide To Revealing Your Body's Life Changing Secrets For Renewed Health" available on Amazon at* ***http://amzn.to/TmPgZW***. Dr. Johnson is also the author of the eBooks:*"The Ultimate Strategy for Ending Your Thyroid Symptoms so YOU Can Increase the Zest in Your Life", "The Ultimate Strategy for Ending Your Vertigo, Dizziness AND Brain Fog", "The Ultimate Strategy for Ending Your Fibromyalgia and Chronic Pain",* and *"The Ultimate Strategy for Ending Migraines AND Other Debilitating Headaches".*

www.JohnsonHealthandWellness.com - www.DrKarlJohnson.com - www.ReadReclaimYourLife.com

ADD/ADHD/ASPERGER'S/PDD-NOS CHILD CLIENT APPLICATION

Welcome to Johnson Health & Wellness Center!

We specialize in helping clients achieve their highest level of health through our natural health care support programs.

This application is extensive because we are committed to being thorough with your care. The questions we ask provide important information that will help us determine whether or not we can help you. You deserve the best, so please give us yours when you answer these questions.

Please remember to sign the last page indicating you have thoroughly completed this application and **return this application and any lab and diagnostic test results you've had (in the last 6-12 months) at least two business days prior** to your scheduled appointment. This must be accomplished before your consultation. Please feel free to call us if you need assistance.

Thank you, we look forward to serving you.

Autism Spectrum Disorder / ADD / ADHD / Dyslexia / PPD-NOS
Confidential Client Intake Form

If you require more space for any of these answers, please attach additional information.
Please complete this application in pen or electronic format.

Date:_____/_____/ ____ Email address: _____

Client Full Name: _____

Name of Parent or Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____

Last four Social Security Numbers: _____ Client's Birth Date: ___/_____/ _____

~~How~~ did you hear about our office? _____

List Chiropractors you have seen before:

1. Name: _____
   Condition/When: _____
2. Name: _____
   Condition/When: _____

List Medical Doctors consulted within the past year:

1. Name: _____ Address: _____
   When: _____ Reason for visit? _____
2. Name: _____ Address: _____
   When: _____ Reason for visit? _____

Current Medications	What condition are you taking this for?	Dosage
1.		
2.		
3.		
4.		
5.		

List your child's health challenge according to severity (ADD,ADHD, ETC.)	Date parent 1st noticed symptom	Date Diagnosed	Is disorder getting better or worse?
1.			
2.			
3.			

1. **Please rate the following health challenges on a 0-10 scale*** (0 = not at all, 10 = Worst you can imagine)

____Anxiety	____Learning Disorder	____Poor Concentration
____Depression	____Unable to Focus	____Obsessive Behavior
____ADD /ADHD	____Memory Problems	____Insomnia (getting to sleep)
____Fatigue	____Headaches	____Insomnia (staying asleep)
____Mood Swings	____Ringing in Ears	____Difficulty Moving Body Parts

***What behavior do you desire the most to be extinguished?** _____

2. **Have any other family member been diagnosed with Autism Spectrum Disorders, ADD, ADHD or Dyslexia?** YES ___ / NO ___ If yes, please list relationship: _____

3. **Have any other family members been diagnosed with an autoimmune disease (Rheumatoid Arthritis, Lupus, Scleroderma, MS, Thyroid Disease, Autoimmune Diabetes, other)?** YES ___ / NO ___ If yes, please list relationship: _____

4. **Is there a family history of (if so, who)?**
   a. Any psychiatric conditions? _____
   b. Any Autism Spectrum conditions? _____
   c. Any diagnosed autoimmune conditions? _____
   d. Any known genetic conditions? _____

5. **Mom's pre-pregnant health?**
   a. Miscarriages? _____
   b. Fertility Treatments? _____
   c. Health of other children? _____
   d. Physical Abuse? _____
   e. Major Illnesses? _____
   f. Known Autoimmune Conditions (Rheumatoid Arthritis, Lupus, MS, Hashimoto's)? _____
   g. Toxin Exposure:
      Molds ___Y ___N
      Pesticides ___Y ___N
      Dental Work ___Y ___N
   h. Known Infections _____ Yeast _____ Bacterial _____ Parasite
   i. Did Mom (While Pregnant)
      Drink Alcohol ___Y ___N
      Drink Coffee ___Y ___N
      Smoke Tobacco ___Y ___N
      Take Progesterone ___Y ___N
      Take Antibiotics ___Y ___N

Take other Drugs ___Y ___N

Have viral infection ___Y ___N

Have bleeding ___Y ___N

Group B strep infection ___Y ___N

Excessive vomiting, nausea (more than 3 weeks) ___Y ___N

Was Mom overweight ___Y ___N _____lbs

Has Mom been tested for gene SNP's _____

6. **Birth**

a. During the child's delivery, were forceps or suction used? _____

b. Was birth by C-section? _____

c. Was labor induced? _____

d. Did Mother have an epidural? _____

e. What was child's APGAR score _____ at one minute / _____ at 5 minutes

Comments about birth _____

7. **Infancy**

a. Was child exposed to mold? _____

b. Was the child exposed to pesticides? _____

c. Was the house painted, either inside or outside? _____

8. **Motor development**

a. At what age did your child do the following?

Sit up	**Crawl**	**Stand Up**	**Walk Alone**	**Potty-Trained**
_____	_____	_____	_____	_____
Dry at Night	**First words**	**Speak Clearly**	**Lost Language**	**Lost Eye contact**
_____	_____	_____	_____	_____

b. Did your child display any cute behaviors when learning to crawl or walk? (for ex: dragging one leg, or crawling on all fours with rear end up in the air) _____

c. How long did mother breast feed? Months ____/ Never ____

d. How long was the child bottle-fed? _____

e. Was formula soy based? _____ Casein (milk) based? _____

f. Did baby have any reactions to the formula? If so, describe _____

g. What age was cow's milk introduced? _____

h. At what age was rice introduced? _____

i. At what age were wheat and/or other grains introduced? _____

9. **Early Childhood**
   a. Number of earaches in first two years _____
   b. Number of times you had antibiotics in the first two years_____
   c. Number of courses of prophylactic antibiotics in the first two years_____
   d. First antibiotic at? _____
   e. First illness at? _____
   f. Has your child been vaccinated? _____

   If vaccinated, did your child have any of the following after the vaccines?
   Diarrhea _____ Crying _____ Swelling at injection site? _____ Seizure _____
   Fever _____ Irritable _____ Other _____

Name of all infections during first two years of life	Age of onset
1.	
2.	
3.	
4.	
5.	

10. **Current Diet**
   a. Does your child refuse to eat particular textures, temperatures, or certain kinds of food?
      Describe: _____
   b. Does your child eat a lot of or crave a lot of any of the following?
      Sweets (cookies, candy, sugar)?_____
      Dairy products (milk, cheese, ice cream) _____
      Sweet drinks (Gatorade, Powerade, Capri Sun, Sunny-D, Soda, Fruit Juices)
      _____
      Salty Foods_____
   c. Does your child eat only 2-4 kinds of food daily? _____

11. **Gastrointestinal Issues**
      Does your child suffer from any of the following?
   a. Constipation_____
   b. Diarrhea_____
   c. Bloating_____
   d. Dark circles under the eyes_____
   e. Do the child's behaviors/ symptoms get worse in the following weather?
      Damp_____ Hot_____ Misty_____ Moldy_____ Musty_____
   f. Does the child wake up at night laughing or giggling _____
   g. Does the child put pressure on stomach (w/ hands or by laying over couch arms etc.) ___Y ___N

What have you noticed improves/reduces your child's symptoms? _____
_____

_____

_____

What have you observed aggravates/increases your child's symptoms? _____

_____

Is there any other information you feel may be helpful for the doctor to know? _____

_____

_____

_____

_____

Signature of person that completed this paperwork: _____

A Note from Dr. Johnson…

Parents harbor a special vision for their child's everyday moments.

- An **attentive child listening to the teacher** and excelling in the classroom.
- A grinning face as their little one hands over **a report card filled with high marks** and glowing feedback.
- An engaged athlete, **focused on winning the game and supporting** their teammates.
- A introspective artist **creating their next masterpiece.**

These visions are easily **disrupted by ADD and ADHD**. The ability for their loved one to **focus, learn, be present and engaged is hindered** by the brain. And the solution that most western doctors provide is a lifetime of medication, something many parents are hesitant to do.

At **Johnson Health & Wellness Center,** we use a **combination of Clear Mind neurofeedback exercises and Interactive Metronome exercises to "retrain the brain" and functional medicine practices combined with dietary modification and food sensitivity reduction/elimination** to help your child regain the confidence and focus they need.

Our greatest reward is hearing parents talk about **receiving their first positive report from their child's teacher—and then hearing the child declare they are "smart in school now."**

Nothing warms our hearts more than to see a conflicted and distracted child make a complete transformation and **embrace a life they thought would never be possible— a life filled with focus, achievement, confidence and a joy for learning.**

…Please continue filling out the application in the pages that follow

CONTINUED NARRATIVE OF CHIEF COMPLAINT

Please provide a detailed description of events in chronological order (please include dates) immediately preceding the development of your condition and through today. Additionally, you may use this space to provide additional information you feel will help us assess your case.

Continue on next page if additional room is needed

(Additional Info ❒ Attached ❒ On Back)

LIFE IMPACT ASSESSMENT

As you answer the following questions, please do not minimize any impact on your child's health challenge on you and your family's life no matter how small it appears. We consider any loss of ability or function which affects you or your child's daily life as significant. **Please check as many that apply; add additional comments in the margin or on the back as needed.**

How have others been affected by your child's health condition? ❒No one is affected ❒Haven't noticed any problem
❒They tell me to do something ❒People avoid my child ❒Other: _____

What are you afraid this might be (or is beginning) to affect (or will affect) in any way?
❒Energy ❒Child's mood / attitude ❒Stress ❒Job ❒Child's self-esteem ❒Future ability ❒Marriage
❒Any relationships (frequency visiting, quality, etc.) ❒ Your self-esteem ❒Sleep ❒Time
❒Finances ❒Freedom ❒Other: _____

Are there health conditions you are afraid this might turn into? ❒Family health problems
❒Allergies ❒Asthma ❒Anxiety ❒Autism ❒Depression
❒ More serious neurological disorder ❒Other: _____

How has your child's health condition affected your job, relationships, finances, family, or other activities?
Please give examples: _____
_____
_____
_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) **Try to give 3 examples**:
_____
_____
_____

What are you most concerned with regarding your child's problem? _____
_____
_____

Where do you picture your child being in the next 1-3 years if this problem is not taken care of?
_____

What would be different/better without this problem? Please be specific _____
_____
_____

What do you desire most to get from working with us? _____
_____
_____
_____

If you could achieve your desire, what is that worth to you? _____
_____
_____

ASSESSMENT & TREATMENT GOALS

In spite of the fact that you are not a specialist, what, in your opinion, do you think the real problem is?

_____

_____

Would you consider this problem **(check one)**?

❒ MINIMAL (Annoying but causing NO limitations)
❒ SLIGHT (Tolerable but causing a little limitation)
❒ MODERATE (Sometimes tolerable but causing limitations)
❒ SEVERE (Causing significant limitations and/or concern)
❒ EXTREME (Causing near constant (Limits you > 80% of the time)

Which best describes your goals for your child's health:

❑ Symptom Relief Only (not interested in correction of the problem).

❑ Would like to find the cause of this problem and have it improved or corrected.

How strong is your desire to correct this problem ❒ Mild ❒ Moderate ❒ High ❒ Extremely High

❑ Wellness / Preventative care – I just want my child to stay well and be at optimal health

How supportive is your Spouse/Family/Significant Other to you seeking care for your child? (Be very specific)

_____

_____

Are you able to handle a complete investigation and management of your child's case? _____

_____

What is YOUR idea of an ideal doctor? _____

_____

There may be services that your insurance company does not cover. If this is the case, we have many reasonable and affordable payment options. If you have a problem that we can help, would you be willing to pay out of pocket for your child to get better? ❒ Yes ❒ No

Based on your child's consultation, history and exam findings, your child may require additional tests that require payment at time of service. If this is required, you will be informed in advance.

Method of payment for any additional uncovered services today: ❒ Cash ❒ Check ❒ Credit Card

I, _____ (**Please Print Full Name of Parent or Guardian**), have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. Additionally, I have read and reviewed all supportive information that has been included with my child's application – this may include written or recorded material. If I do not have the means to review the material, I have contacted Johnson Health & Wellness Center to arrange for additional support. I understand that failure to complete this application fully and review the enclosed material may mean the doctor will not be able to conduct the consultation and evaluation of my child. I will also bring any labs, images or reports which have been requested in this application. I give this office permission to communicate with me via mail, telephone and email.

Signature: _____ Date: _____

Please Note:

In the following paperwork you may notice there are repeat questions.

Please answer all of the questions as there are different forms and paperwork that will be assessed differently.

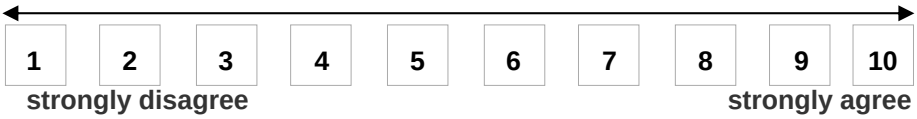
Thank you!

Pre IM Survey

Please complete the following survey, which will help identify and quantify areas of your daily performance, which **may be improved by IM**. Answers will be kept confidential.

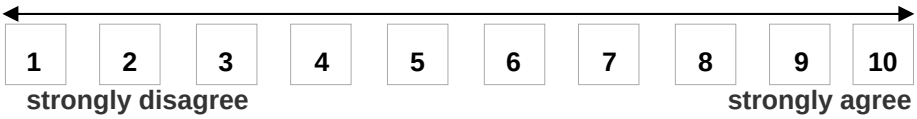
A. Memory recall

I have a good memory. (e.g. I remember lists of items to buy and information I hear.)



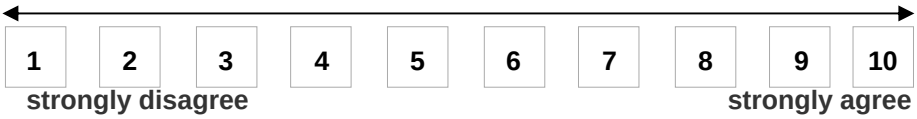
B. Organizational skills

I am generally well organized. (e.g. I keep items in order and consistently in their place.)



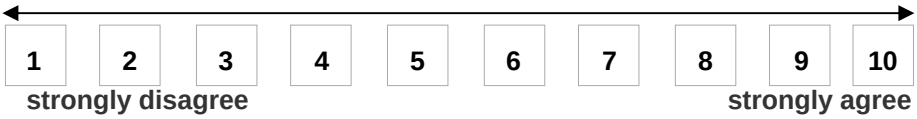
C. Concentration/Focus

I have good concentration skills. (e.g. I can read or work without being easily distracted.)



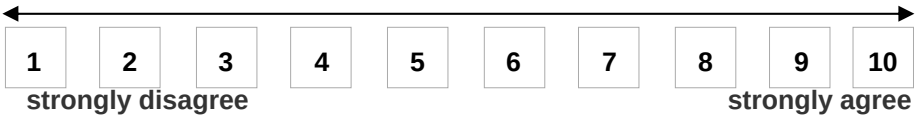
D. Multi-tasking

I can manage multiple tasks at one time. (e.g. I can converse while also writing.)



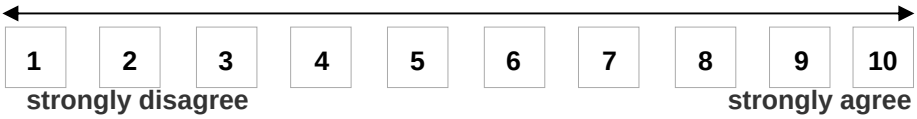
E. Coping skills

I have good coping skills. (e.g. I do not become frustrated easily or overreact to issues.)



F. Rhythm/Timing

I have good rhythm. (e.g. I can "keep the beat" to music.)



Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Clumsiness and an odd posture

___Poor coordination

___Not athletically inclined and has no interest in popular childhood participation sports

___Low muscle tone – muscles seem kind of floppy

___Poor gross motor skills, such as difficulty learning to ride a bike and/or runs and/or walks oddly

___Repetitive/stereotyped motor mannerisms (spins in circles, flaps arms)

___Fidgets excessively

___Poor eye contact

___Walks or walked on toes when younger

___Poor spatial orientation – bumps into things often

___Sensitivity to sound

___Confusion when asked to point to different body parts

___Poor sense of balance

___High threshold for pain – doesn't cry when gets a cut

___Likes to spin, go on rides, swing, etc. – anything with motion

___Touches things compulsively

___A girl uninterested in makeup or jewelry

___Does not like the feel of clothing on arms or legs; pulls off clothes

B

___Fine motor problems (poor or slow handwriting)

___Difficulty with fine motor skills, such as buttoning a shirt

___Tends to write very large for age or grade level

___Stumbles over words when fatigued

___Exhibited delay in crawling, standing, and/or walking

___Loves sports and is good at them

___Good muscle tone

___Poor drawing skills

___Difficulty learning to play music

___Likes to fix things with the hands and is interested in anything mechanical

___Difficulty planning and coordinating body movements

___Doesn't seem to have many sensory issues or problems, such as a sensitivity to sound

___Has good spatial awareness

___Has good sense of balance

___Eats just about anything

___Has a normal to above-average sense of taste and smell

___Likes to be hugged and held

___Does not have any oddities concerning clothing

___Has auditory processing problems

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Doesn't like being touched and doesn't like to touch things

___Incessantly smells everything

___Prefers bland foods

___Does not notice strong smells, such as burning wood, popcorn, or cookies baking in the oven

___Avoids food because of the way it looks

___Hates having to eat and is not even interested in sweets

___Extremely picky eater

___Spontaneously cries and/or laughs and has sudden outbursts of anger or fear

___Worries a lot and has several phobias

___Holds on to past "hurts"

___Has sudden emotional outbursts that appear over-reactive and inappropriate to the situation

___Experiences panic and/or anxiety attacks

___Sometimes displays dark or violent thoughts

___Face lacks expression; doesn't exhibit much body language

___Too uptight; cannot seem to loosen up

___Lacks empathy and feelings for others

___Lacks emotional reciprocity

___Often seems fearless and is a risk taker

___Logical thinker

___Often misses the gist of a story

___Didn't look at self in mirror as a toddler

B

___Seems not to hear well, although hearing tests normal

___Delay in speaking was attributed to ear infections

___Gets motions sickness and has other motion sickness issues

___Is not undersensitive or over sensitive to pain

___Overly happy and affectionate; loves to hug and kiss

___Frequently moody and irritable

___Loves doing new or different things but gets bored easily

___Lacks motivation

___Withdrawn and shy

___Excessively cautious, pessimistic, or negative

___Doesn't seem to get any pleasure out of life

___Socially withdrawn

___Cries easily; feelings get hurt easily

___Seems to be in touch with own feelings

___Empathetic to other people's feelings; reads people's emotions well

___Gets embarrassed easily

___Very sensitive to what others think about him or her

___Procrastinates

___Is extremely shy, especially around strangers

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

- ___Gets stuck in set behavior; can't let it go
- ___Lacks social tact and/or is antisocial and/or socially isolated
- ___Poor time management; is always late
- ___Disorganized
- ___Has a problem paying attention
- ___Is hyperactive and/or impulsive
- ___Has obsessive thoughts or behaviors
- ___Argues all the time and is generally uncooperative
- ___Exhibits signs of an eating disorder
- ___Failed to thrive as an infant
- ___Mimics sounds or words repeatedly without really understanding the meaning
- ___Appears bored, aloof, and abrupt
- ___Considered strange by other children
- ___Inability to form friendships
- ___Has difficulty sharing enjoyment, interests, or achievements with other people
- ___Inappropriately giddy or silly
- ___Acts inappropriately in social situations
- ___Talks incessantly and asks the same question repetitively
- ___Has no or little joint attention, such as the need to point to an object to get your attention
- ___Poor math reasoning (word problems, geometry, algebra)

B

- ___Is very good at nonverbal communication
- ___Is well liked by other children and teachers
- ___Does not have any behavioral problems in school
- ___Understands social rules
- ___Has poor self esteem
- ___Hates doing homework
- ___Is very good at social interaction
- ___Makes good eye contact
- ___Likes to be around people and enjoys social activities, such as going to parties
- ___Doesn't like to go to sleepovers
- ___Is not good at following routines
- ___Can't follow multiple-step directions
- ___Is in touch with own feelings
- ___Jumps to conclusions
- ___Very good at big picture skills
- ___Is an intuitive thinker and is led by feelings
- ___Good at abstract "free" association
- ___Has a bedwetting problem
- ___Has or had an irregular heartbeat, such as an arrhythmia or a heart murmur
- ___Poor analytical skills
- ___Very visual; loves images and patterns

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Poor reading comprehension and pragmatic skills

___Misses the big picture

___Very analytical

___Likes "slapstick" or obvious physical humor

___Is very good at finding mistakes (spelling)

___Takes everything literally

___Doesn't always reach a conclusion when speaking

___Started speaking early

___Has tested for a high IQ, but scores run the whole spectrum; or IQ is above normal in verbal ability and below average in performance abilities

___Was an early word reader

___Is interested in unusual topics

___Learns in a rote (memorizing) manner

___Learns extraordinary amounts of specific facts about a subject

___Is impatient

___Speaks in a monotone; has little inflection

___Is a poor nonverbal communicator

___Doesn't like loud noises (like fireworks)

___Speaks out loud regarding what he or she is thinking

___Talks "in your face" – is a space invader

B

___Constantly questions why you're doing something or why rules exist

___Has poor sense of time

___Enjoys touching and feeling actual objects

___Has trouble prioritizing

___Is unlikely to read instructions before trying something new

___Is naturally creative, but needs to work hard to develop full potential

___Would rather do things instead of observe

___Uses good voice inflection when speaking

___Misreads or omits common small words

___Has difficulty saying long words

___Reads very slowly and laboriously

___Had difficulty naming colors, objects, and letters as a toddler

___Needs to hear or see concepts many times to learn them

___Has shown a downward trend in achievement test scores or school performance

___Schoolwork is inconsistent

___Was a late talker

___No allergies

___Has difficulty pronouncing words (poor with phonics)

___Had difficulty learning the alphabet, nursery rhymes, or songs when young

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Good reader but does not enjoy reading

___Analytical; led by logic

___Follows rules without questioning them

___Good at keeping track of time

___Easily memorizes spelling and mathematical formulas

___Enjoys observing rather than participating

___Would rather read an instructions manual before trying something new

___Math was often the first academic subject that became a problem

___Has lots of allergies

___Rarely gets colds and infections Has had or has eczema or asthma

___Skin has little white bumps, especially on the backs of the arms

___Displays erratic behavior – good one day, bad the next

___Craves certain foods, especially dairy and wheat products

___Problems with bowels, such as constipation and diarrhea

___Has a rapid heart rate and/or high blood pressure for age

___Appears bloated, especially after meals, and often complains of stomach pains

___Has body odor /Sweats a lot

___Hands are always moist and clammy

___Always the last to get a joke

B

___Acts before thinking and makes careless mistakes

___Daydreams a lot

___Has difficulty sequencing events in the proper order

___Often writes letters backward

___Is poor at basic math skills

___Has poor memorization skills

___Has poor academic ability

___Has an IQ lower than expected and verbal scores are lower than nonverbal scores

___Performs poorly on verbal tests

___Needs to be told to do something several times before acting on it

___Stutters or stuttered when younger

___Is a poor speller

___Doesn't read directions well

___Gets chronic ear infections

___Prone to benign tumors or cysts

___Has taken antibiotics more than 10 to 15 times before the age of ten

___Has had tubes put in the ears

___Catches colds frequently

___Has difficulty finishing homework or finishing a conversation

The highest number of check marks show which side of the brain is weaker.

Total Number (A) ___1___ Right side

Total Number (B) ___0___ Left side

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Please circle the appropriate number "0 - 3" on all questions below. **0 as the least/never to 3 as the most/always.**

SECTION: GENERAL

Does your child have any food sensitivities or allergies? (please list)

_____

_____

List your child's 4 healthiest foods eaten regularly.

_____, _____,

_____, _____

List your child's 4 unhealthiest foods eaten regularly.

_____, _____,

_____, _____

How many times a week does your child eat candy? _____

How many times a week does your child drink soda pop? _____

List the top 4 foods your child craves regularly.

_____, _____,

_____, _____

List the medication(s) your child is currently prescribed and over the counter.

_____

_____

Do you find it difficult as a parent to have your child on a special diet?

_____

SECTION: A (K52, K60)

Does your child eat pasta, breads, and breaded foods?	0	1	2	3
Does your child have symptoms (fatigue, hyperactivity, etc.) after eating foods containing wheat/gluten?	0	1	2	3
Does your child consume dairy products?	0	1	2	3
Does your child have symptoms (fatigue, hyperactivity, etc.) after consuming dairy products?	0	1	2	3

SECTION: B (K54)

Does your child eat fried fish?	0	1	2	3
Does your child eat roasted nuts or seeds?	0	1	2	3
Is your child **missing** essential fatty acid-rich foods in his/her diet? (for example: avocados, flax seeds, olives) *(circle "0" if present, "3" if missing)*	0	1	2	3
Does your child eat fried foods?	0	1	2	3

SECTION: C (K34)

Is your child's mental speed slow?	0	1	2	3
Does your child have difficulty with learning or memory?	0	1	2	3
Does your child have difficulty with balance and coordination?	0	1	2	3

SECTION: D (K16)

Does your child have stress?	0	1	2	3
Does your child **not** have enough sleep and rest? *(circle "3" if not enough)*	0	1	2	3
Does your child **not** have regular exercise? *(circle "3" if no exercise)*	0	1	2	3
Does your child feel overly worried and scared?	0	1	2	3

SECTION: E (K16, K51)

Does your child have temper tantrums?	0	1	2	3
Does your child exhibit wild behavior?	0	1	2	3
Does your child frequently yell or scream for unnecessary reasons?	0	1	2	3
Does your child have an **inability** to nap or sleep when physically exhausted? *(circle "3" if unable)*	0	1	2	3
Is your child overly talkative?	0	1	2	3
Does your child fidget and squirm when seated?	0	1	2	3
Does your child run and climb excessively when it is inappropriate?	0	1	2	3
Does your child have difficulty playing quietly or engaging in leisure activities?	0	1	2	3

SECTION: F (K51)

Does your child get excited easily?	0	1	2	3
Does your child have anxiousness and panic for minor reasons?	0	1	2	3
Does your child feel overwhelmed for minor reasons?	0	1	2	3
Does your child find it difficult to relax when he/she is awake?	0	1	2	3
Does your child have disorganized attention?	0	1	2	3

SECTION: G (K50)

Does your child seem depressed?	0	1	2	3
Does your child have mood changes with overcast weather?	0	1	2	3
Does your child have symptoms of inner rage?	0	1	2	3
Does your child seem uninterested in games or hobbies?	0	1	2	3
Does your child have difficulty falling into deep restful sleep?	0	1	2	3
Does your child seem uninterested in friendships?	0	1	2	3
Does your child have symptoms of unprovoked anger?	0	1	2	3
Does your child seem uninterested in eating?	0	1	2	3

SECTION: H (K49)

Does your child have difficulty handling stress?	0	1	2	3
Does your child have anger and aggression while being challenged?	0	1	2	3
Does your child feel tired even after long sleeps?	0	1	2	3
Does your child tend to isolate from others?	0	1	2	3
Does your child get distracted easily?	0	1	2	3
Does your child have constant need and desire for candy and sugar?	0	1	2	3
Does your child have disorganized attention?	0	1	2	3

SECTION: I (K48)

Does your child have difficulty with visual memory?	0	1	2	3
Does your child have difficulty remembering locations?	0	1	2	3
Does your child have fatigue or low endurance for learning activities?	0	1	2	3
Does your child have difficulty with attention or low attention span or endurance?	0	1	2	3
Does your child have slow or difficult speech?	0	1	2	3
Does your child have uncoordinated or slow movement?	0	1	2	3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

SMGECNNQ01(033011).INDD

****IMPORTANT****

PLEASE READ THIS PAGE CAREFULLY

In order for your child to get better as fast as possible, we need the help of ALL persons significantly involved in your child's support system. Spouses, friends, and family members all play a crucial role in your child's treatment and the results that they achieve. In short, it is extremely important that all of your child's support systems are "on the same page".

Therefore, we require that all persons directly involved with your child's support system watch the online condition specific video or the DVD sent to you and then sign this affidavit. This form must be returned with the Client Application and Case Review forms before Dr. Karl R.O.S. Johnson, DC can examine your child.

AFFIDAVIT

I (each) the undersigned individual certifies that:

- I understand that Dr. Johnson's methods and care are unique.
- I understand that Dr. Johnson does not accept every person into his care program.

_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature

Thank you for taking the time to make sure your child gets the best results possible in the fastest amount of time.

Please return this paper with your Client Application forms.

RESET SAVE PRINT SEND